House Bill 1064

By: Representatives Tumlin of the 38th, Lindsey of the 54th, and Lane of the 167th

A BILL TO BE ENTITLED

AN ACT

To amend Title 31 of the Official Code of Georgia Annotated, relating to health, so as to revise the statutory living will form; to provide for automatic revocation of a health care agency by the execution of a subsequent agency; to revise the statutory health care power of attorney form; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 31 of the Official Code of Georgia Annotated, relating to health, is amended by striking subsection (b) of Code Section 31-32-3, relating to execution of living wills, witnesses, and forms; and inserting in its place the following:

"(b) The declaration shall be a document, separate and self-contained. Any declaration which constitutes an expression of the declarant's intent shall be honored, regardless of the form used or when executed. Declarations executed on or after March 28, 1986, shall be valid indefinitely unless revoked. A declaration similar to the following form or in substantially the form specified under prior law shall be presumed on its face to be valid and effective:

'LIVING WILL

Living will made this _____ day of _____ (month, year).

I, _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be prolonged under the circumstances set forth below and do declare:

1. If at any time I should (~~check each option desired~~ my initials indicate each option desired):

(A-) Have ~~have~~ a terminal condition;~~,~~

_____(Initial)

(B–) Become ~~become~~ in a coma with no reasonable expectation of regaining consciousness;~~,~~

_____(Initial)

or

(C-) Become ~~become~~ in a persistent vegetative state with no reasonable expectation of regaining significant cognitive function,

_____(Initial)

as defined in and established in accordance with the procedures set forth in paragraphs (2), (9), and (13) of Code Section 31-32-2 of the Official Code of Georgia Annotated, I direct that the application of life-sustaining procedures to my body (~~check the~~ my initials indicate the option desired):

(A-) Including ~~including~~ nourishment and hydration~~,~~ **(I will receive no nourishment or fluids)**

_____(Initial)

(B-) Including ~~including~~ nourishment but not hydration **(I will receive fluids, but not nourishment)**~~, or~~

_____(Initial)

(C) Including hydration but not nourishment **(I will receive nourishment, but not fluids)**

_____(Initial)

or

(D–) Excluding ~~excluding~~ nourishment and hydration **(I will receive nourishment and fluids)**~~,~~

_____(Initial)

be withheld or withdrawn and that I be permitted to die;

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this living will shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal;

3. I understand that I may revoke this living will at any time;

4. I understand the full import of this living will, and I am at least 18 years of age and am emotionally and mentally competent to make this living will; and

5. If I am a female and I have been diagnosed as pregnant, this living will shall have no force and effect unless the fetus is not viable and I indicate by initialing after this sentence that I want this living will to be carried out. _____(Initial)

Signed _____

_____(City), _____(County), and _____(State of Residence).

I hereby witness this living will and attest that:

(1) The declarant is personally known to me and I believe the declarant to be at least 18 years of age and of sound mind;

(2) I am at least 18 years of age;

(3) To the best of my knowledge, at the time of the execution of this living will, I:

(A) Am not related to the declarant by blood or marriage;

(B) Would not be entitled to any portion of the declarant´s estate by any will or by operation of law under the rules of descent and distribution of this state;

(C) Am not the attending physician of declarant or an employee of the attending physician or an employee of the hospital or skilled nursing facility in which declarant is a patient;

(D) Am not directly financially responsible for the declarant´s medical care; and

(E) Have no present claim against any portion of the estate of the declarant;

(4) Declarant has signed this document in my presence as above instructed, on the date above first shown.

Witness _____

Address _____

Witness _____

Address _____

Additional witness required when living will is signed in a hospital or skilled nursing facility.

I hereby witness this living will and attest that I believe the declarant to be of sound mind and to have made this living will willingly and voluntarily.

Witness: _____

Medical director of skilled

nursing facility or staff

physician not participating

in care of the patient or
chief of the hospital
medical staff or staff
physician or hospital
designee not participating
in care of the patient.'"

SECTION 2.

Said title is further amended by striking subsection (a) of Code Section 31-36-6, relating to revocation or amendment of agency, and inserting in its place the following:

"(a) Every health care agency may be revoked by the principal at any time, without regard to the principal's mental or physical condition, by any of the following methods:

(1) By being obliterated, burned, torn, or otherwise destroyed or defaced in a manner indicating an intention to revoke;

(2) By a written revocation of the agency signed and dated by the principal or by a person acting at the direction of the principal; ~~or~~

(3) By the execution of a subsequent health care agency, unless such subsequent agency explicitly states that the previous health care agency is not revoked; or

~~(3)~~(4) By an oral or any other expression of the intent to revoke the agency in the presence of a witness 18 years of age or older who, within 30 days of the expression of such intent, signs and dates a writing confirming that such expression of intent was made."

SECTION 3.

Said title is further amended by striking subsection (a) of Code Section 31-36-10, relating to form of power of attorney for health care and authorized powers, and inserting in its place the following:

"(a) The statutory health care power of attorney form contained in this subsection may be used to grant an agent powers with respect to the principal's own health care; but the statutory health care power is not intended to be exclusive or to cover delegation of a parent's power to control the health care of a minor child, and no provision of this chapter shall be construed to bar use by the principal of any other or different form of power of attorney for health care that complies with Code Section 31-36-5. If a different form of power of attorney for health care is used, it may contain any or all of the provisions set forth or referred to in the following form. When a power of attorney in substantially the following form is used, and notice substantially similar to that contained in the form below

has been provided to the patient, it shall have the same meaning and effect as prescribed in this chapter. Substantially similar forms may include forms from other states. The statutory health care power may be included in or combined with any other form of power of attorney governing property or other matters:

'GEORGIA STATUTORY SHORT FORM
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR AGENT) BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU, INCLUDING POWER TO REQUIRE, CONSENT TO, OR WITHDRAW ANY TYPE OF PERSONAL CARE OR MEDICAL TREATMENT FOR ANY PHYSICAL OR MENTAL CONDITION AND TO ADMIT YOU TO OR DISCHARGE YOU FROM ANY HOSPITAL, HOME, OR OTHER INSTITUTION; BUT NOT INCLUDING PSYCHOSURGERY, STERILIZATION, OR INVOLUNTARY HOSPITALIZATION OR TREATMENT COVERED BY TITLE 37 OF THE OFFICIAL CODE OF GEORGIA ANNOTATED. THIS FORM DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS; BUT, WHEN A POWER IS EXERCISED, YOUR AGENT WILL HAVE TO USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS FORM. A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THE AGENT IS NOT ACTING PROPERLY. YOU MAY NAME COAGENTS AND SUCCESSOR AGENTS UNDER THIS FORM, BUT YOU MAY NOT NAME A HEALTH CARE PROVIDER WHO MAY BE DIRECTLY OR INDIRECTLY INVOLVED IN RENDERING HEALTH CARE TO YOU UNDER THIS POWER. UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THIS POWER IN THE MANNER PROVIDED BELOW OR UNTIL YOU REVOKE THIS POWER OR A COURT ACTING ON YOUR BEHALF TERMINATES IT, YOUR AGENT MAY EXERCISE THE POWERS GIVEN IN THIS POWER THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME DISABLED, INCAPACITATED, OR INCOMPETENT. THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO REVOKE THOSE POWERS, AND THE PENALTIES FOR VIOLATING THE LAW ARE EXPLAINED MORE FULLY IN CODE SECTIONS 31-36-6, 31-36-9, AND 31-36-10 OF THE GEORGIA "DURABLE POWER OF ATTORNEY FOR HEALTH CARE ACT" OF WHICH THIS FORM IS A PART (SEE THE BACK OF THIS FORM). THAT ACT EXPRESSLY PERMITS THE USE OF ANY DIFFERENT

FORM OF POWER OF ATTORNEY YOU MAY DESIRE. IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

DURABLE POWER OF ATTORNEY made this _____ day of _____, ____.

1. I, _____

_____ (insert name and address of principal) _____

hereby appoint _____ (insert name and address of agent) _____

as my attorney in fact (my agent) to act for me and in my name in any way I could act in person to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and health care and to require, withhold, or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. This shall include the authority to serve as my personal representative for all purposes of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), P.L. 104-191, and its implementing regulations, during any time that my agent is exercising authority under this document. This authority shall include, but not be limited to, all rights that I have under HIPAA regarding the use and disclosure of my individually identifiable health information and other medical records. My agent shall also have full power to make a disposition of any part or all of my body for medical purposes, authorize an autopsy of my body, and direct the disposition of my remains.

THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF NOURISHMENT AND FLUIDS AND OTHER LIFE-SUSTAINING OR DEATH-DELAYING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT´S POWERS OR PRESCRIBE SPECIAL RULES TO LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY, OR DISPOSE OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as your own definition of when life-sustaining or death-delaying measures should be withheld; a direction to continue nourishment and fluids or other life-sustaining or death-delaying treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or

unacceptable to you for any other reason, such as blood transfusion, electroconvulsive therapy, or amputation):

_____

_____

_____

THE SUBJECT OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT, BUT DO NOT INITIAL MORE THAN ONE:

I do not want my life to be prolonged nor do I want life-sustaining or death-delaying treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining or death-delaying treatment.

Initialed _____

I want my life to be prolonged and I want life-sustaining or death-delaying treatment to be provided or continued unless I am in a coma, including a persistent vegetative state, which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered such an irreversible coma, I want life-sustaining or death-delaying treatment to be withheld or discontinued.

Initialed _____

I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures.

Initialed _____

THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU AT ANY TIME AND IN ANY MANNER WHILE YOU ARE ABLE TO DO SO. IN THE ABSENCE OF AN AMENDMENT OR REVOCATION, THE AUTHORITY GRANTED IN THIS POWER OF ATTORNEY WILL BECOME EFFECTIVE AT THE TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH

AND WILL CONTINUE BEYOND YOUR DEATH IF ANATOMICAL GIFT, AUTOPSY, OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:

3. ( ) This power of attorney shall become effective on _____ (insert a future date or event during your lifetime, such as court determination of your disability, incapacity, or incompetency, when you want this power to first take effect).

4. ( ) This power of attorney shall terminate on _____ (insert a future date or event, such as court determination of your disability, incapacity, or incompetency, when you want this power to terminate prior to your death).

IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND ADDRESSES OF SUCH SUCCESSORS IN THE FOLLOWING PARAGRAPH:

5. If any agent named by me shall die, become legally disabled, incapacitated, or incompetent, or resign, refuse to act, or be unavailable, I name the following (each to act successively in the order named) as successors to such agent:

_____

_____

IF YOU WISH TO NAME A GUARDIAN OF YOUR PERSON IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED, YOU MAY, BUT ARE NOT REQUIRED TO, DO SO BY INSERTING THE NAME OF SUCH GUARDIAN IN THE FOLLOWING PARAGRAPH. THE COURT WILL APPOINT THE PERSON NOMINATED BY YOU IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. YOU MAY, BUT ARE NOT REQUIRED TO, NOMINATE AS YOUR GUARDIAN THE SAME PERSON NAMED IN THIS FORM AS YOUR AGENT.

6. If a guardian of my person is to be appointed, I nominate the following to serve as such guardian:

(insert name and address of nominated guardian of the person)

7. INITIAL ONE:

I have previously signed a durable power of attorney for health care. I want it to remain in effect in addition to this document, except in instances where the previous power of attorney and this document conflict. In such a conflict, this document shall prevail.

Initialed

I have previously signed a durable power of attorney for health care, and I HEREBY REVOKE IT.

Initialed

I DO NOT have a previously signed durable power of attorney for health care.

Initialed

~~7.~~8. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed _____

(Principal)

The principal has had an opportunity to read the above form and has signed the above form in our presence. We, the undersigned, each being over 18 years of age, witness the principal´s signature at the request and in the presence of the principal, and in the presence of each other, on the day and year above set out.

Witnesses:	Addresses:
_____	_____
	_____
_____	_____
	_____

Additional witness required when health care agency is signed in a hospital or skilled nursing facility.

I hereby witness this health care agency and attest that I believe the principal to be of sound mind and to have made this health care agency willingly and voluntarily.

Witness:_____

Attending Physician

Address:_____

_____

YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.

Specimen signatures of

I certify that the signature of my agent and successor(s) is

agent and successor(s) correct.

_____ _____

(Agent) (Principal)

_____ _____

(Successor agent) (Principal)

_____ _____

(Successor agent) (Principal)"

SECTION 4.

All laws and parts of laws in conflict with this Act are repealed.